		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004721

Facility Name: GENESEO GOOD SAMARITAN VILLAGE

Address: 704 SOUTH ILLINOIS STREET (Number) GENESEO (City) 61254 (Zip Code)

County: HENRY

Telephone Number: (309) 944-6424 **Fax #** (309) 944-6605

IDPA ID Number: 45-0228055

Date of Initial License for Current Owners: 1/1/1970

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: KIM KOURI **Telephone Number:** (605) 362-3178

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Raye Nae Nylander

(Title) Vice President/CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,480	13,439	1,915	24,834	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,480	13,439	1,915	24,834	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.50%

D. How many bed-hold days during this year were paid by the Department?
3 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1/1/1971

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	170,441	13,835	5,320	189,596		189,596	(170)	189,426			1
2	Food Purchase		146,782		146,782		146,782	(1,533)	145,249			2
3	Housekeeping	94,056	18,408		112,464		112,464	(231)	112,233			3
4	Laundry	71,710	21,001		92,711		92,711	(293)	92,418			4
5	Heat and Other Utilities			97,437	97,437		97,437		97,437			5
6	Maintenance	86,983	10,558	79,487	177,028		177,028	(2,347)	174,681			6
7	Other (specify):*			10,409	10,409		10,409	(88)	10,321			7
8	**TOTAL General Services**	423,190	210,584	192,653	826,427		826,427	(4,662)	821,765			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,223,435	125,873	5,217	1,354,525	(3,278)	1,351,247	(42,250)	1,308,997			10
10a	Therapy	4,183	553	224,810	229,546		229,546	(117,036)	112,510			10a
11	Activities	64,596	8,541	3,138	76,275		76,275	(744)	75,531			11
12	Social Services	43,438	77	885	44,400		44,400	(1)	44,399			12
13	CNA Training					3,278	3,278		3,278			13
14	Program Transportation			4,574	4,574		4,574		4,574			14
15	Other (specify):*	32,958			32,958		32,958		32,958			15
16	**TOTAL Health Care and Programs**	1,368,610	135,044	238,624	1,742,278		1,742,278	(160,031)	1,582,247			16
	C. General Administration											
17	Administrative	37,524		140,996	178,520		178,520	3,852	182,372			17
18	Directors Fees											18
19	Professional Services			1,710	1,710		1,710		1,710			19
20	Dues, Fees, Subscriptions & Promotions			30,256	30,256		30,256	(23,383)	6,873			20
21	Clerical & General Office Expenses	69,214	22,746	37,423	129,383		129,383	(7,454)	121,929			21
22	Employee Benefits & Payroll Taxes			389,227	389,227		389,227	(20,427)	368,800			22
23	Inservice Training & Education			19,129	19,129	(147)	18,982	(1,616)	17,366			23
24	Travel and Seminar			3,443	3,443	147	3,590	(2,992)	598			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,231	36,231		36,231	4,684	40,915			26
27	Other (specify):* **Marketing & Res Dev**	11,769		8,684	20,453		20,453	(20,678)	(225)			27
28	**TOTAL General Administration**	118,507	22,746	667,099	808,352		808,352	(68,014)	740,338			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,910,307	368,374	1,098,376	3,377,057		3,377,057	(232,707)	3,144,350			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE #0004721 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			172,921	172,921		172,921	(23,459)	149,462			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11	11		11	(11)				32
33	Real Estate Taxes			9,691	9,691		9,691	(9,691)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,835	2,835		2,835		2,835			35
36	Other (specify):*											36
37	**TOTAL Ownership**			185,458	185,458		185,458	(33,161)	152,297			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		38		38		38	(38)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,501	39,501		39,501		39,501			42
43	Other (specify):*			5,875	5,875		5,875	(5,874)	1			43
44	**TOTAL Special Cost Centers**		38	45,376	45,414		45,414	(5,912)	39,502			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,910,307	368,412	1,329,210	3,607,929		3,607,929	(271,780)	3,336,149			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,758)	2		4
5	Telephone, TV & Radio in Resident Rooms	(589)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	2,132	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,840)	6		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,383)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(234,613)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (261,051)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(10,729)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (10,729)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (271,780)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GENESEO GOOD SAMARITAN VILLAGE

ID# 0004721

Report Period Beginning: 1/1/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	UNIFORM	$ (2,304)	21	1
2	ADMINISTRATION	(1,860)	21	2
3	OPERATIONS/MAINTENANCE	(212)	6	3
4	POSTAGE	(39)	21	4
5	RESIDENT SUPPLIES	(88)	7	5
6	TELEPHONE	(100)	21	6
7	ACTIVITY	(36)	11	7
8	INT INC PAST DUE ACCTS	(34)	21	8
9	P/F INT EXP - NC	(11)	32	9
10	DEFERRED MAINT COSTS - 2005	767	6	10
11	DEPR EXP - APTS AND DUPLEXES	(23,459)	30	11
12	REAL ESTATE TAXES	(9,691)	33	12
13	PRESCR DRUGS - REIMB	(40,201)	10	13
14	BARBER/BEAUTY EXPENSES	(38)	40	14
15	SALARIES - RES DEV	(5,997)	27	15
16	BANK CHARGES	(80)	21	16
17				17
18	VAC ACCRUAL - RES DEV	225	2	18
19	FICA - RES DEV	(459)	22	19
20	SUPPLIES - RES DEV	(3,778)	21	20
21	SM EQUIP - RES DEV	(765)	21	21
22	MISC FUNDRAISER EXP	(8,684)	27	22
23	TRAVEL - RES DEV	(955)	24	23
24	STAFF DEV - RES DEV	(1,616)	23	24
25	TRAVEL - OUT OF STATE	(1,890)	24	25
26	P/SERV-LABORATORY-MDCR	(5,263)	43	26
27	THERAPY OFFSET - PT, OT, ST	(117,030)	10a	27
28	SALARIES - MARKETING	(5,997)	27	28
29	P/SERV - CLINIC	(611)	43	29
30	**FICA -MARKETING**	(459)	22	30
31	SUPPLIES - MARKETING	-466	21	31
32	STAFF PENSION - RES DEV	-122	22	32
33	MED SUPPLIES - PT B	-960	10	33
34	STAFF PENSION - MARKETING	-122	22	34
35	Discount Allow - Admin	-145	21	35
36	Discount Allow - Purchasing	-15	21	36
37	Discount Allow - Nursing	-1023	10	37
38	Discount Allow - Pharmacy	-62	10	38
39	Discount Allow - PT	-5	10a	39
40	Discount Allow - OT	-1	10a	40
41	Discount Allow - HIM	-4	10	41
42	Discount Allow - Activities	-119	11	42
43	Discount Allow - Social Services	-1	12	43
44	Discount Allow - Laundry	-293	4	44
45	Discount Allow - Housekeeping	-231	3	45
46	Discount Allow - Dietary	-170	1	46
47	Discount Allow - Operations/Maintenance	-62	6	47
48	Adj Travel to Reclasses	-147	24	48
49	**Total**	(234,613)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(170)	0	0	0	0	0	0	0	0	0	0	(170)	1
2	Food Purchase	(1,533)	0	0	0	0	0	0	0	0	0	0	(1,533)	2
3	Housekeeping	(231)	0	0	0	0	0	0	0	0	0	0	(231)	3
4	Laundry	(293)	0	0	0	0	0	0	0	0	0	0	(293)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,347)	0	0	0	0	0	0	0	0	0	0	(2,347)	6
7	Other (specify):*	(88)	0	0	0	0	0	0	0	0	0	0	(88)	7
8	**TOTAL General Services**	(4,662)	0	0	0	0	0	0	0	0	0	0	(4,662)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(42,250)	0	0	0	0	0	0	0	0	0	0	(42,250)	10
10a	Therapy	(117,036)	0	0	0	0	0	0	0	0	0	0	(117,036)	10a
11	Activities	(744)	0	0	0	0	0	0	0	0	0	0	(744)	11
12	Social Services	(1)	0	0	0	0	0	0	0	0	0	0	(1)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(160,031)	0	0	0	0	0	0	0	0	0	0	(160,031)	16
	C. General Administration													
17	Administrative	0	3,852	0	0	0	0	0	0	0	0	0	3,852	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(23,383)	0	0	0	0	0	0	0	0	0	0	(23,383)	20
21	Clerical & General Office Expenses	(7,454)	0	0	0	0	0	0	0	0	0	0	(7,454)	21
22	Employee Benefits & Payroll Taxes	(1,162)	(19,265)	0	0	0	0	0	0	0	0	0	(20,427)	22
23	Inservice Training & Education	(1,616)	0	0	0	0	0	0	0	0	0	0	(1,616)	23
24	Travel and Seminar	(2,992)	0	0	0	0	0	0	0	0	0	0	(2,992)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,684	0	0	0	0	0	0	0	0	0	4,684	26
27	Other (specify):*	(20,678)	0	0	0	0	0	0	0	0	0	0	(20,678)	27
28	**TOTAL General Administration**	(57,285)	(10,729)	0	0	0	0	0	0	0	0	0	(68,014)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(221,978)	(10,729)	0	0	0	0	0	0	0	0	0	(232,707)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE **#** 0004721 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(23,459)	0	0	0	0	0	0	0	0	0	0	(23,459)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11)	0	0	0	0	0	0	0	0	0	0	(11)	32
33	Real Estate Taxes	(9,691)	0	0	0	0	0	0	0	0	0	0	(9,691)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(33,161)	0	0	0	0	0	0	0	0	0	0	(33,161)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(38)	0	0	0	0	0	0	0	0	0	0	(38)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(5,874)	0	0	0	0	0	0	0	0	0	0	(5,874)	43
44	**TOTAL Special Cost Centers**	(5,912)	0	0	0	0	0	0	0	0	0	0	(5,912)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(261,051)	(10,729)	0	0	0	0	0	0	0	0	0	(271,780)	45

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Admin Acctg	$ 140,996	Evangelical Lutheran Good Samaritan Society	100.00%	$ 144,848	$ 3,852	1
2	V	22	Workers Comp	71,693			58,718	(12,975)	2
3	V	22	Unemploy Charges Paid	3,796			3,770	(26)	3
4	V	26	Insurance	36,230			40,914	4,684	4
5	V	22	Group Health Ins	131,213			124,949	(6,264)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 383,928			$ 373,199	$ * (10,729)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAG # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2						NO ALLOCATION NECESSARY				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	NOT APPLICABLE						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE **#** 0004721 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	**8**
	2001	**9**
	2002	**10**
	2003	**11**
	2004	**12**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GENESEO GOOD SAMARITAN VILLAGE COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0004721

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,848 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

APARTMENTS - 8 UNITS
DUPLEXES - 21 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1969	$ 26,000	1
2					2
3	TOTALS			$ 26,000	3

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		1971	1971	$ 494,740	$ 12,368	40	$ 12,368	$	$ 429,805	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building										9
10				1977	1,100		VARIES			1,100	10
11				1978	7,629		20			7,629	11
12				1981	168,876	5,451	VARIES	5,451		138,893	12
13				1982	2,299		VARIES			2,299	13
14				1986	2,926	15	VARIES	15		2,926	14
15				1987	15,313	520	VARIES	520		14,533	15
16				1988	123,266	5,248	VARIES	5,248		109,513	16
17				1989	26,987	168	VARIES	168		19,524	17
18				1990	108,416	5,163	VARIES	5,163		90,516	18
19				1991	3,157	53	VARIES	53		3,126	19
20				1992	36,755	1,204	VARIES	1,204		31,376	20
21				1993	37,071	648	VARIES	648		34,780	21
22				1994	69,096	2,971	VARIES	2,971		51,477	22
23				1995	76,363	4,460	VARIES	4,460		49,802	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Cont'd		$	$		$	$	$	37
38	CERAMIC FLOORING/BATHROOM QA-M	1996	107	5	20	5		53	38
39	LAUNDRY WALL PROTECTION	1996	1,109					1,109	39
40	ACTIVITY ROOM REMODEL/SINK	1996	2,132					2,132	40
41	LAUNDRY DOORS Q/A	1996	1,874	125	15	125		1,228	41
42	BATHROOM SINK	1996	678	34	20	34		336	42
43	AWNING FOR REHAB CLINIC	1996	983	98	10	98		958	43
44									44
45	KEMLITE IN CLOSETS	1996	653	65	10	65		631	45
46	POWER ACCESS DOOR OPERATOR	1996	1,009	101	10	101		975	46
47	GENERATOR/MOVE TO GSS	1996	3,431	343	10	343		3,316	47
48	CARPET FOR PARLOR	1996	2,627		5			2,499	48
49	A/C-ROOF TOP ON 200 WING	1996	229	15	15	15		145	49
50	ELECTRIC-REMODEL PARLOR	1996	186	9	20	9		88	50
51	BUILDING-REMODEL PARLOR	1996	1,132	57	20	57		537	51
52	PLUMBING-REMODEL PARLOR	1996	599	30	20	30		285	52
53	WALLPAPER-REMODEL PARLOR	1996	2,645		5			2,517	53
54	SHOWER REMODEL-GRAB BARS	1996	1,321	132	10	132		1,222	54
55	REPLACE FIXTURES/FLOOR/WALL	1996	3,955	198	20	198		1,813	55
56	WINDOWS	1996	25,212	1,681	15	1,681		15,407	56
57	BUILDING-REMODEL	1996	1,692	85	20	85		797	57
58	WINDOW FOR DINING ROOM	1997	1,650	110	15	110		981	58
59	300 WING CEILING TILE WORK	1997	2,584		5			2,584	59
60	WALL BUILT IN LAUNDRY ROOM	1997	1,013	101	10	101		904	60
61	WINDOWS	1997	5,100	340	15	340		3,032	61
62	WALLPAPER FOR JACK ANDREWS	1997	2,221		5			2,221	62
63	CARPET FOR CONFERENCE ROOM	1997	2,192		5			2,192	63
64	CONFERENCE ROOM WORK	1997	1,350	135	10	135		1,203	64
65	WALL PROTECTION	1997	739		5			739	65
66	NEW SPRINKLERS FOR OFFICE	1997	909	91	10	91		788	66
67	WALLPAPER-RESIDENT ROOM 308	1997	2,667		5			2,667	67
68	CARPET FOR RESIDENT ROOM	1997	506		5			506	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,246,499	$ 42,024		$ 42,024	$	$ 1,041,168	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,246,499	$ 42,024		$ 42,024	$	$ 1,041,168	1
2	Building Cont'd								2
3									3
4	ROOF-FRONT ENTRY	1997	21,178	1,059	20	1,059		9,442	4
5	SOCIAL SERVICE & CONFERENCE TOOM	1997	1,392	93	15	93		789	5
6	D.O.N. & STAFF DEVELOPMENT OFFICE	1997	1,236	82	15	82		700	6
7	WALLPAPER-ROOM 308	1997	1,440		5			1,440	7
8	DRAIN/SEWER WORK	1997	389	26	15	26		218	8
9	REMODEL WORK IN ROOM 309	1997	1,464	98	15	98		797	9
10	SIDERAIL 1/2 DELUXE	1997	958	64	15	64		522	10
11	SIDERAILS	1997	556	37	15	37		300	11
12	DRYWALL-NURSE STATION	1997	625		5			625	12
13	REHAB WALL WORK	1997	414		5			414	13
14	REROOFING	1997	64,129	3,206	20	3,206		26,186	14
15	BUILDING-REMODEL NURSES STATION	1998	18,510	740	25	740		5,923	15
16	CARPET-REMODEL NURSES STATION	1998	1,753		5			1,753	16
17	WALLCOVERING-REMODEL NURSES STATION	1998	1,794		5			1,794	17
18	FORM & POUR LAMP POST BASES	1998	800		5			800	18
19	SIDE RAILS	1998	812	54	15	54		433	19
20	KITCHEN DOOR	1998	1,242	83	15	83		642	20
21	CABINETRY & INSTALLATION	1998	3,799	190	20	190		1,472	21
22	ROOM 204 WORK	1998	2,532	253	10	253		1,962	22
23	VINYL COVERING-KICK PLATES	1998	1,367	137	10	137		1,060	23
24	HANDRAIL & INSTALLATION	1998	700	47	15	47		361	24
25	FIRE ALARM SYSTEM WORK	1998	1,090	109	10	109		836	25
26	BATHROOM FIXTURES	1998	412	41	10	41		312	26
27	ROOF FLASHING INSTALLATION	1998	753	75	10	75		571	27
28	KOROGUARD IN MED ROOM AND BATH	1998	1,008	101	10	101		764	28
29									29
30	GENERATOR	1998	47,534	2,377	20	2,377		18,420	30
31	BOILER TANK	1998		32	10	32			31
32	DOOR FRAME GUARDS	1998	593	40	15	40		297	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,424,979	$ 50,968		$ 50,968	$	$ 1,120,000	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,424,979	$ 50,968		$ 50,968	$	$ 1,120,000	1
2	Building Cont'd								2
3									3
4	WATER HEATER	1998	1,339	134	10	134		993	4
5	FLOORCOVERING CEILING TILE	1998	1,398		5			1,398	5
6	RESIDENT ROOM WORK	1998	996		5			996	6
7	CEILING TILE	1998	20,525	1,026	20	1,026		7,526	7
8	2000 PROJECT	1998	6,817	341	20	341		2,471	8
9	BATHROOM WORK	1998	2,121	212	10	212		1,537	9
10	AIR CONDITIONING	1998	24,279	1,624	15	1,624		11,423	10
11	HVAC SYSTEMS	1998	4,284	287	15	287		2,016	11
12	ALUMINUM ENTRANCE/AMBULANCE	1999	1,726	115	15	115		796	12
13	ROOF WORK	1999	2,800	280	10	280		1,843	13
14	WOOD SIGN	1999	327	33	10	33		210	14
15	HVAC SYSTEMS	1999	2,350	235	10	235		1,547	15
16	PLUMBING-BATHROOM REMODEL	1999	4,739	237	20	237		1,580	16
17	BUILDING-REMODEL RESIDENT ROOM	1999	6,265	251	25	251		1,546	17
18	DRAPES-REMODEL RESIDENT ROOM	1999	279		5			279	18
19	ELECTRIC-REMODEL RESIDENT ROOM	1999	197	10	20	10		61	19
20	PAINT/REMODEL RESIDENT ROOM	1999	2,697		5			2,697	20
21	FAUCETS	2000	1,159	58	20	58		324	21
22	OAK CABINETS FOR KITCHEN	2000	1,603	107	15	107		614	22
23	LAUNDRY REPAIR	2000	533	27	5	27		533	23
24	WATER SOFTENER	2000	541	54	10	54		275	24
25	MAINTENANCE GARAGE	2001	79,709	5,314	15	5,314		25,684	25
26	BLDG-REDECORATE 300 WING COORD	2001	8,062	322	25	322		1,451	26
27	CARPET-REDECORATE 300 WING	2001	1,986	397	5	397		1,787	27
28	FIRE ALARM CONTROL PANEL	2001	414	41	10	41		179	28
29	GENERATOR REPAIR	2000	2,258	226	10	226		1,167	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,604,383	$ 62,298		$ 62,298	$	$ 1,190,933	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,604,383	$ 62,298		$ 62,298	$	$ 1,190,933	1
2	BUILDING CONTINUED								2
3	WORK ON HEAT UNITS	2001	3,856	386	10	386		1,575	3
4	FURNACE	2001	508	51	10	51		203	4
5	LAMINATE CABINETS-ACT.ROOM	2002	2,779	185	15	185		710	5
6	PHONE CABLE WIRING TO ROOMS	2002	700	70	10	70		257	6
7	AIR CONDITIONERS-BUILDING A	2002	6,175	617	10	617		2,367	7
8	BUILDING -REMODEL RESIDENT RMS	2002	32,873	1,315	25	1,315		4,821	8
9	CAULKING-REMODEL RESIDENT RMS	2002	193	19	10	19		71	9
10	CERAMIC TILE-REMDL RESIDENT RM	2002	181	9	20	9		33	10
11	CORNER GUARD-REMDL RESIDENT RM	2002	90	9	10	9		33	11
12	DRAPES-REMDL RES RM	2002	1,152	230	5	230		845	12
13	DRAPERY RODS-REMDL RES RM	2002	174	17	10	17		64	13
14	WALLPAPER-REMDL RES RM	2002	1,809	362	5	362		1,327	14
15	BLINDS-REMDL RESIDENT RM	2002	533	107	5	107		391	15
16	CARPET-THERAPY	2002	622	124	5	124		394	16
17	BUILDING-REDECORATE 100/200	2002	11,912	476	35	476		1,588	17
18	CARPET-REDECORATE 100/200	2002	5,069	1,014	5	1,014		3,379	18
19	CORNER GUARDS-REDEC 100/200	2002	170	17	10	17		57	19
20	DOORS-REDECORATE 100/200	2002	199	13	15	13		44	20
21	WALLPAPER-REDECORATE 100/200	2002	1,905	381	5	381		1,270	21
22									22
23	SOLID CORE DOORS/SNF	2003	1,656	110	15	110		313	23
24									24
25	LIGHTING FIXTURES	2003	6,755	676	10	676		1,576	25
26									26
27	BLDG-REMODEL	2003	5,173	207	25	207		500	27
28	WINDOWS	2003	2,494	166	15	166		360	28
29	DUAL SENSOR SMOKE ALARM	2003	1,276	128	10	128		266	29
30									30
31	TILE FOR DIETARY OFFICE	2004	775	78	10	78		142	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,693,412	$ 69,066		$ 69,066	$	$ 1,213,519	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,693,412	$ 69,066		$ 69,066	$	$ 1,213,519	1
2	BUILDING CONTINUED:								2
3	REPAIR DINING ROOM ROOF	2004	3,253	325	10	325		542	3
4									4
5	BLINDS-RESIDENT ROOM REMODEL	2004	1,257	252	5	252		272	5
6	BUILDING-RESIDENT ROOM REMODEL	2004	23,806	952	25	952		1,032	6
7	DRAPES-RESIDENT ROOM REMODEL	2004	66	13	5	13		14	7
8	ELECTRIC-RESIDENT ROOM REMODEL	2004	1,109	55	20	55		60	8
9	WALLPAPER-RESIDENT ROOM RMDEL	2004	88	18	5	18		19	9
10	CERAMIC FLOOR FOR KITCHEN	2005	1,280	53	20	53		53	10
11	FIRE SPRINKLER SYSTEM	2005	111,341	3,340	25	3,340		3,340	11
12	BOILER REPLACEMENT	2005	107,947	5,397	20	5,397		5,397	12
13	CEILING TILE	2005	7,373	277	20	277		277	13
14	REKEY BUILDING	2005	5,753	288	10	288		288	14
15	REKEY CAMPUS	2005	6,484	54	10	54		54	15
16	FIRE PROTECTION SYSTEM UPGRADE	2005	20,284	338	10	338		338	16
17									17
18									18
19									19
20	Disposal of Boiler - #29291			(691)		(691)			20
21	Disposal of Boiler - #30031			(2,504)		(2,504)			21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,983,452	$ 77,233		$ 77,233	$	$ 1,225,205	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,983,452	$ 77,233		$ 77,233	$	$ 1,225,205	1
2	LAND IMPROVEMENTS								2
3	DRIVES-GRADING-WALKS	1971	9,171		15			9,171	3
4	BLACKTOP	1973	5,865		15			5,865	4
5	PAVING	1974	3,499		15			3,499	5
6	IMPROVE WEST SIDE OF PARKING	1975	1,018		15			1,018	6
7	DIRT-EE SNODGRASS	1975	83		15			83	7
8	RESURFACE PARKING LOT	1978	3,817		15			3,817	8
9	SIDEWALK AROUND CENTER-DRAIN	1981	3,842		20			3,796	9
10	SOD AROUND BLDG	1981	1,450		10			1,450	10
11	PAVING-ASPHALT	1985	6,089		15			6,089	11
12	SEED	1990	803		10			803	12
13	DEMOLITION OF HOUSES	1990	2,985		10			2,985	13
14	LANDSCAPE	1990	69		10			69	14
15	GAZEBO	1991	11,223	561	20	561		7,996	15
16	ISABEL BLOOM FOR MEMORIAL	1992	300	20	15	20		270	16
17	ILLUMINATED SIGN BOX AND COVE	1992	5,288		12			5,288	17
18	TO LAY BRICKS FOR NEW SIGN	1992	383		12			383	18
19	LANDSCAPING MATERIAL	1992	2,764		10			2,764	19
20	GAZEBO	1995	9,618	641	15	641		6,572	20
21	FENCE	1995	6,242	416	15	416		4,265	21
22	BURY ELECTRIC LINE	1996	3,347	335	10	335		3,319	22
23									23
24	GAZEBO	1997	2,850	143	20	143		1,235	24
25	WALK	1997	2,500	167	15	167		1,444	25
26	ENTRANCE AREA LANDSCAPING	1997	2,450	245	10	245		2,062	26
27	SPRINKLER SYSTEM	1997	726	48	15	48		392	27
28	PARKING LOT	1997	2,266	113	20	113		935	28
29	COURTHOUSE RESEARCH FOR PREP	1998	515	52	10	52		408	29
30	PATIO	1998	1,313	131	10	131		974	30
31	SKYLIGHT & FLASHING WORK	1998	1,607	161	10	161		1,192	31
32									32
33	PARKING LOT-CHESTNUT STREET	1988	62,030		15			62,030	33
34	TOTAL (lines 1 thru 33)		$ 2,137,564	$ 80,265		$ 80,265	$	$ 1,365,377	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,137,564	$ 80,265		$ 80,265	$	$ 1,365,377	1
2	LAND IMPROVEMENTS CONTINUED								2
3	SIDEWALK	1999	475	48	10	48		313	3
4	BLOCKS/RETENTION POND	2001	1,128	56	20	56		245	4
5	FENCING AROUND SCREEN	2002	1,520	152	10	152		519	5
6	PARKING LOT LAMP POSTS	2003	508	51	10	51		148	6
7	STRIPING PARKING LOT	2004	839	168	5	168		210	7
8	REHAB SHED	2005	2,948	221	10	221		221	8
9	SLAB FOR BUILDING	2005	1,723	38	15	38		38	9
10	BENCH FOR MEMORIAL GARDEN	2005	321	8	10	8		8	10
11	BRICKS FOR MEMORIAL GARDEN	2005	350	6	20	6		6	11
12	PARKING LOT EXPANSION	1999	13,797	690	20	690		4,254	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,161,173	$ 81,703		$ 81,703	$	$ 1,371,339	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 475,575	$ 46,067	$ 46,067	$		$ 297,155	71
72	Current Year Purchases	131,038	7,709	7,709			8,070	72
73	Fully Depreciated Assets	385,456	3,273	3,273			384,877	73
74	Prior Yr Depr		497	497				74
75	TOTALS	$ 992,069	$ 57,546	$ 57,546	$		$ 690,102	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT CARE	19 PASSENGER VAN	1998	$ 46,953	$	$	$	3	$ 46,953	76
77		WHEELCHAIR BELTS FOR VA	2003	795	199	199		4	480	77
78		2004 DODGE RAM TRUCK	2003	20,807	3,468	3,468		6	6,936	78
79		SNOWPLOW ON VEHICLE	2004	3,359	840	840		4	1,610	79
80	TOTALS			$ 71,914	$ 4,506	$ 4,506	$		$ 55,978	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,251,156	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,756	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,756	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,117,419	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LAND	$ 160,693	$	$	86
87	BUILDING	2,969,803	99,743	765,803	87
88	LAND IMP	82,846	3,687	35,218	88
89	FFE	95,144	3,488	66,762	89
90	NON-CARE ASSETS ALLOC TO 01	529,987	23,459	119,316	90
91	TOTALS	$ 3,838,473	$ 130,377	$ 987,099	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 429,100	92
93			93
94			94
95		$ 429,100	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$ 0		$	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 0	$ 0	$ 0	$ 0		$ 0	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT CARE	2000 Chrysler Minivan	2004	$ 13,700	$ 2,283	$ 2,283	$ 0	6	$ 3,806	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 13,700	$ 2,283	$ 2,283	$ 0		$ 3,806	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,200,873	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 83,986	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,986	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,375,145	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 2,833 Description: NETWORK COMPUTER LEASE, ONE TIME RENTALS
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER CNA	88

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	X
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 994	$	$ 994
2	Books and Supplies		230		230
3	Classroom Wages (a)		1,414		1,414
4	Clinical Wages (b)		640		640
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 3,278	$	$ 3,278
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,278			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		969	hrs	$ 78,279		$	$	969	$ 78,279	1
2	Licensed Speech and Language Development Therapist		450	hrs	41,531				450	41,531	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist		1185	hrs	104,998				1,185	104,998	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 224,808		$	$	2,604	$ 224,808	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE **#** 0004721 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 165,693	$	1
2	Cash-Patient Deposits	4,758		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	396,843		3
4	Supply Inventory (priced at)	6,895		4
5	Short-Term Investments	1,483,798		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,301		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,062,288	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	160,693		13
14	Buildings, at Historical Cost	5,432,329		14
15	Leasehold Improvements, at Historical Cost	311,480		15
16	Equipment, at Historical Cost	1,172,827		16
17	Accumulated Depreciation (book methods)	(3,108,325)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	65,512		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Asset Mgmnt, CIP	429,961		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,464,477	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,526,765	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 46,551	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,158		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	206,732		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,511		31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,009		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Group Ins, Garnishments, Misc W/H	247		36
37	Security Dep/Priority Pymnt	31,250		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 381,458	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Refd-Dplx Ent Fee, Non Refd-Dplx Ent Fe	1,747,925		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,747,925	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,129,383	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,397,382	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,526,765	$	48

***(See instructions.)**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,427,195	1	
2	Restatements (describe):		2	
3	CONGREGATE	19,085	3	
4	APARTMENTS	9,192	4	
5	DUPLEXES	30,379	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,485,851	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	29,460	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) DNR RST PROP, OPER, OPER GFT-GRANT	3,900	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 33,360	17	
	B. Transfers (Itemize):			
18	CASH ASSET ASSESS	(88,527)	18	
19	INTRA-CO N/A-NC	(33,302)	19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (121,829)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,397,382	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,607,984	1
2	Discounts and Allowances for all Levels	(852,341)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,755,643	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	19,079	5
6	Therapy	681,077	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 700,156	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	690	12
13	Barber and Beauty Care	1,071	13
14	Non-Patient Meals	1,758	14
15	Telephone, Television and Radio	100	15
16	Rental of Facility Space	26,380	16
17	Sale of Drugs	83,850	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 113,849	23
	D. Non-Operating Revenue		
24	Contributions	20,867	24
25	Interest and Other Investment Income***	47,603	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 68,470	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NSG & MED SUPPLIES	30,692	28
28a	SCHEDULE ATTACHED	(31,421)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (729)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,637,389	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	826,427	31
32	Health Care	1,742,278	32
33	General Administration	808,352	33
	B. Capital Expense		
34	Ownership	185,458	34
	C. Ancillary Expense		
35	Special Cost Centers	5,913	35
36	Provider Participation Fee	39,501	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,607,929	40
41	**Income before Income Taxes (line 30 minus line 40)****	29,460	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 29,460	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,880	2,135	$ 54,654	$ 25.60	1
2	Assistant Director of Nursing	192	192	4,167	21.70	2
3	Registered Nurses	7,334	8,103	165,178	20.38	3
4	Licensed Practical Nurses	8,546	9,602	156,620	16.31	4
5	CNAs & Orderlies	60,163	66,325	724,368	10.92	5
6	CNA Trainees					6
7	Licensed Therapist	190	190	4,183	22.02	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,809	2,134	28,555	13.38	9
10	Activity Assistants	4,084	4,412	35,640	8.08	10
11	Social Service Workers	2,455	3,018	45,820	15.18	11
12	Dietician					12
13	Food Service Supervisor	2,009	2,162	31,229	14.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,017	16,553	137,838	8.33	15
16	Dishwashers					16
17	Maintenance Workers	6,350	6,997	85,686	12.25	17
18	Housekeepers	8,690	9,530	91,832	9.64	18
19	Laundry	6,084	6,639	69,832	10.52	19
20	Administrator	1,204	1,337	37,202	27.82	20
21	Assistant Administrator					21
22	Other Administrative	5,686	6,095	80,966	13.28	22
23	Office Manager	1,231	1,361	18,970	13.94	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,245	2,410	32,372	13.43	31
32	Other Health Care(specify)	4,292	4,805	86,111	17.92	32
33	Other(specify) Market/Res Dev	772	850	11,994	14.11	33
34	TOTAL (lines 1 - 33)	140,233	154,850	$ 1,903,217 *	$ 12.29	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	111	$ 5,320	Ln 1, Col 3	35
36	Medical Director	12	1,200	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,916	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	1,328	Ln 11, Col 3	44
45	Social Service Consultant	7	1,071	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	143	$ 10,834		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1	$ 25	Ln 10, Col 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1	$ 25		53

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mike Olsen		100	$ 37,202
Vacation Accrual			322
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 37,524

B. Administrative - Other

Description	Amount
Admin/Acctg Serv	$ 140,996
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 140,996

C. Professional Services

Vendor/Payee	Type	Amount
58000 National Campus		$ 10
64540 National Campus	Medicare Cost Report Prep	800
64541 National Campus	Medicaid Cost Report Prep	900
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 1,710

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,718
Unemployment Compensation Insurance	3,770
FICA Taxes	140,906
Employee Health Insurance	124,949
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Taxable Gifts Pymts	1,605
Staff Pension	37,457
Admin/Consultant Savings	1,395
TOTAL (agree to Schedule V, line 22, col.8)	$ 368,800

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Publications - Reimb	1,058
Public Relations - Reimb	4,434
Dues - Reimb	5,815
Advert/Promo - Admin, Res Dev/Market	17,118
Newsletter - Marketing	
Less: Marketing/Res Dev	(17,118)
Less: Public Relations Expense	(4,434)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,873

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,890
(Res Dev)	584
In-State Travel	577
Seminar Expense	539
Less: Adj Travel Due To Reclass	(147)
Less: Out of State Travel	(1,890)
Less: Res Dev Travel	(955)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 598

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	WALLPAPER	7/00	$ 1,295	5	$ 259	$ 259	$ 259	$ 130	$	$	$	$	$
2	WALLPAPER/PAINT	12/00	2,533	5	507	507	507	464					
3	PAINT	6/00	64	5	13	13	12	6					
4	PAINT	2/01	496	5	105	105	105	91					
5	PAINT	6/01	348	5	93	93	93	34					
6	PAINT	6/01	120	5	32	32	32	12					
7	PAINT	6/01	192	5	51	51	51	20					
8	PAINT	8/01	70	5	21	21	21	4					
9	PAINT	8/01	68	5	20	20	20	4					
10	PAINT	8/01	30	5	9	9	9	2					
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,216		$ 1,110	$ 1,110	$ 1,109	$ 767	$	$	$	$	$

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Life Services Network, $4487**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **11**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,292** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **39,501**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **1,757**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **25%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **HENRY SCHOLTEN & COMPANY** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.